CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMP 09/13/2	(X3) DATE SURVEY COMPLETED 09/13/2011	
	PROVIDER OR SUPPLIER		2727 CI	ADDRESS, CITY, STATE, ZIP COD ROWNPOINTE CIRCLE RSON, IN46012	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
R0000	Complaint #IN00 State Residential the allegations ar R349.  Unrelated State I are cited.  Survey dates: Se Facility number: Provider number AIM number: N Survey Team: Ginger McName Betty Retherford  Census bed type: Residential: 40 Total: 40  Census payor type Medicaid: 8 Other: 32 Total: 40  Sample: 4	deficiencies related to re cited at R52, R214, and Residential deficiencies eptember 12 and 13, 2011 012129 :: 012129 //A ee, RN, TC , RN (9/12/11)	R0000	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL B. WINC	DING	00	COMPL 09/13/2	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 CROWNPOINTE CIRCLE ANDERSON, IN46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
P0052	in accordance wi Quality review c Cathy Emswiller						
R0052	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.  Based on record review, observation, and interview, the facility failed to ensure each resident was free from neglect related to a lack of evaluation and monitoring following an elopement from the facility and an expression of suicidal ideations with the potential for self harm for 1 of 1 resident reviewed for protection from self harm in sample of 4. (Resident #B)  Findings include:  The clinical record for Resident #B was reviewed on 9/12/11 at 9:35 a.m.		RO	052	Current elopement Risk - Resident B was evaluated I mental health clinician who recommended that the reside return to the assisted living environment with couseling f anger reaction. Although it w believed by the clinician the residents's exit from the facil was due to anger, and lackin suicidal intent, the facility continues to consider Reside at risk for elopement. The resident has not exhibited exit-seeking behavior nor voi a desire to leave the facility: however, the facility continue every 30 minute checks to confirm whereabouts of the resident until deem no longe appropriate by mental health	ent for ras ity ng ent B iced es the	09/30/2011

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
			A. BUII B. WIN			09/13/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R			ROWNPOINTE CIRCLE		
CDOWN	POINTE OF ANDE	PSON			RSON, IN46012		
	TOINTE OF ANDE	NGON		ANDLIN			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	ŧ	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	were not limited	to, dementia, congestive			clinician. An appointment to		
	heart failure,dial	betes mellitus type 2,			counseling has been scheduled for Resident B on 10/20/11 v		
	Parkinson's dise	ase, and depression.			Dr Melissa Zehr at the Ande		
		-			Center. The family remains		
	The clinical reco	ord indicated Resident #B			agreement with this plan. Sh		
		der for Pristiq (an			Resident B begin to exhibit		
		• `			exit-seeking behavior and /	or	
	1 -	nedication) 60 milligrams			voice suicidal ideations, the		
	one tablet daily	for depression.			physican and family shall be		
					consulted in regard to altern		
	An Elopement R	Risk Assessment, dated			placement.Interventions - The resident continues on every		
	8/11/11, indicate	ed Resident #B was			minute checks to confirm	30	
	assessed to be an	n elopement risk because			whereabouts and to assess		
		and had dementia. The			demeaner in an effort to ide	ntify	
		he resident met the			exit -seeking behavior and/c		
		opement risk but at no			suicidal ideations at the earl		
		-			sign of the same. The menta		
		o leave the facility or			health clinician and family ha	ave	
		ire to leave the facility			deemed the assisted living		
	1	d well to living at the			environment to remain appropriate, thus the facility	vazill	
	facility and it is	felt that the resident is not			continue current intervention		
	at risk and will r	emain at the facility".			unless the Resident's behav		
	The form indica	ted the decision to not			indicates greater supervision	n is	
	seek placement	within a secured facility			needed. As a means to ensu	ure	
	1 ^	sed with the resident			ongoing compliance with en	_	
		ole party and all concurred			each resident is free from ne	•	
					related to a lack of evaluatio		
	with the resident	t remaining at the facility.			monitoring following elopem from the facility and/or	ent	
					expressions of suicidal ideal	tions	
	_	riew on 9/12/11 at 9:40			staff has been addressed in		
	a.m., the Directo	or of Nursing indicated the			regard to immediately report		
	facility was not	a "locked" facility. She			administrative staff any exit	-	
	· ·	he exterior doors were			seeking behavior, elopemen		
		alarm was not on during			/or verbal expressions of sui		
	· ·	rs. She indicated the door			ideations made by any resid	ent.	
	I				Administrative staff shall be		
		ned on at 7:00 p.m. and			responsible to monitor for	,	
	remained on dur	ing the night. She	1		compliance ongoing through	ı	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	ETED
			B. WING			09/13/2	011
			_	CET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		l l		ROWNPOINTE CIRCLE		
CDOWNI	POINTE OF ANDER	NOSI			SON, IN46012		
CROWN	POINTE OF ANDER	RSON	AINI	JEK.	30N, IN40012		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFI	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	$\dashv$	DEFICIENCY)		DATE
	indicated any resident could exit the				review of staff reports daily o		
	building during d	laytime hours and no			scheduled days of work, as v		
	alarm would sou	nd.			as review of shift to shift repo in an effort to identify any	orting	
					concerns with aforementione		
	A nursing note d	lated 8/24/11 at 11:20			behaviors and to affirm that	·	
	a.m., indicated th				should such behavior have b	een	
	a.m., maicated th	ic following.			observed, the same has bee	n	
					reported to administrative sta		
		sident was found out of			immediate intervention, inclu	ding	
		on grass. States she was			evaluation and monitoring.		
	headed to highwa	ay [Highway 32 visible			Should non-compliance be identified, immediate correcti		
	from the entrance	e to the facility] "to throw			action shall be taken.	ve	
	herself in front of	f a car." States she has			action shall be taken.		
	things missing in	room. [Name of home					
	health care agence	<del>-</del>					
	_	t for therapy. Resident					
		to building with therapist.					
	_	n. At 10:30 a.m., [name					
		are agency] nurse was in					
	and was instructed	ed by her director to call					
	911. [Name of h	ome health care agency]					
	nurse called son	and doctor's office.					
	[Name of medica	al doctor] office returned					
	_	to send resident for eval					
	[evaluation]"						
	[ [ ] , a.						
	The next numeine	note entry, dated 8/25/11					
	ĺ	• •					
	at 7:30 a.m., indi	cated the following:					
		ed yesterday evening,					
	time unknown. Up this am. Pleasant and						
	visiting with other	er residents. Telling					
	_	ner trip to ER [emergency					
	room]."						
	J.						

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2727 CROWNPOINTE CIRCLE  ANDERSON, IN46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
IAU	This was the last time of review of The clinical record room evaluation orders resulting the reassessment of the readmission to the an elopement and facility intervent ensure the reside expression of suitable During an interval Nursing (DoN) of the indicated the transfer form with hospital. She indicated the transfer form with hospital. She indicated the ER who sent out, but counce alled the ER who sent out, but counce alled the ER regarded the transfer or if the nurse had called not say for sure in resident's suicidal knew the ambulation indicated the factopy of the emerinformation. She is given to the factory of the information of the get this information.	nursing note entry at n 9/12/11 at 9:35 a.m. rd lacked: any emergency and or possible new from the ER visit; any the resident upon the facility related to being d/or suicide risk, and any the ions put into place to nt's safety following her	IAU			DATE	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE COMP - 09/13/2	LETED	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO		2011
CROWN	POINTE OF ANDER	RSON		SON, IN46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	other changes.					
	9/12/11 at 11:10 home health care the resident in the of the building at staff to the area. down the walkwaround to the sid indicated they are resident had left been in the facility morning. They it continued to sit of area furniture sint the ER. The Down had not been resto the facility after interventions had monitor her. She know what time to the facility on new orders at the During an interventions.	esignee and DoN on a.m., they indicated the agency staff had found e grass around to the side and had summoned facility. The resident had walked ay with her walker e of the building. They e not sure what time the the building, but had try for breakfast that indicated the resident out on the front porch ace she had returned from indicated the resident evaluated upon her return er her elopement and no indicated she did not the resident had returned 8/24/11 or if she had any etime of her return.				
	a copy of the em	dicated she had obtained ergency room discharge nospital. She indicated				
	two new medicat written for the re	tion orders had been sident related to the ER ders were for: Risperdal				

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	PROVIDER OR SUPPLIEF		2727 CI	ADDRESS, CITY, STATE, ZIP CODE ROWNPOINTE CIRCLE SON, IN46012	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	ordered) and Atimedication) 0.5 daily as needed indicated the restollow-up appoint physician in 7 dashe was not awa 9/12/11. The Docalled the reside filled the Rispert "refused" it. She know if the reside needed antianxies She indicated the process of obtain psychiatric referfollow-up on her ideations made of the facility and exprand the facility and exprand the facility be emergency room and/or addressed re-evaluation and During an obsert p.m., Resident # lobby sitting on	ral for the resident to relopement and suicidal on 8/24/11.  time period of 19 days resident eloped from the resident eloped from the research and suicidal ideations recame aware of a discharge information of the resident's need for discharge information of the resident's need for discharge information of the resident's need for discharge information on 9/12/11 at 1:20 B was up in the front a couch near the front ing. Her walker was next				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/13/2011
	PROVIDER OR SUPPLIER		STREET A 2727 C	ADDRESS, CITY, STATE, ZIP CODE ROWNPOINTE CIRCLE RSON, IN46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This State Reside Complaint #IN00	ential tag relates to 0095111.			

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDING	NSTRUCTION 00		(X3) DATE S COMPL 09/13/2	ETED
	ROVIDER OR SUPPLIER		•	2727 CF	DDRESS, CITY, STA ROWNPOINTE ( SON, IN46012	*		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID				(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIV	LAN OF CORRECTION E ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG		ED TO THE APPROPRIATI ICIENCY)	E	DATE
TAG R0090	(g) The administration overall management responsibilities of include, but are not (1) Informing the coccurrence that disafety, or health ounusual occurrence telephone, followed written report only electronic mail to the twenty-four (24) hooccurrences include (A) epidemic outbed (B) poisonings; (C) fires; or (D) major accident of the division can be made to the enpublished by the coccurrence or other tequested by the representative.  (3) Obtaining direct admission of an inverse of age to an (4) Ensuring the fapremises, an accurrence and the composition of the fapremises, an accurrence of the composition of the	ator is responsible for the ent of the facility. The the administrator shall of limited to, the following: division within twenty-four oming aware of an unusual rectly threatens the welfare, of a resident. Notice of the may be made by the division within the out time period. Unusual de, but are not limited to: reaks;  ts.  not be reached, a call shall energency telephone number division.  Indiging for or assisting with the earl, dental, podiatry, or the health care services as resident or resident's legal entor approval prior to the addividual under eighteen (18) andult facility.  accility maintains, on the unter the entor and resident or the past of actual time after the:  In name; and resources worked during the past		TAG				DATE
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 09/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2727 CROWNPOINTE CIRCLE CROWNPOINTE OF ANDERSON ANDERSON, IN46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request I. In regards to resident # B as a Based on record review and interview, the R0090 09/30/2011 result of this incident the facility failed to notify the Indiana State Administrator, Designee and Department of Health (ISDH) of an Health and Services Director unusual occurrence within 24 hours of have reveiwed the facility policy on Unsual Occurences, have becoming aware of the occurrence for 1 of been educated as to the 1 resident reviewed who had eloped from reportable unsual occurence the facility and expressed suicidal quidlines and timely reporting in ideations in a sample of 4. (Resident #B) accordance with ISDH guidelines. II. All residents have the potential to be affected by the Findings include: deficient practice. The Administrator, Designee and The clinical record for Resident #B was Health and Services reviewed on 9/12/11 at 9:35 a.m. Director have reveiwed the policy on Unsual Occurences, have been educated as to the Diagnoses for Resident #B included, but reportable unusal occurence were not limited to, dementia, congestive guidelines and timely reporting for all residents. The heart failure, diabetes mellitus type 2, Accident/Incident Report Form Parkinson's disease, and depression. has been up dated to include reportable occurence and An Elopement Risk Assessment, dated date filed. III. As a means of 8/11/11, indicated Resident #B was ongoing compliance with reporting unsual occurences all assessed to be an elopement risk because staff will be educated on the she was mobile and had dementia. The Unusal Occurences Policy, form indicated the resident met the what occurences are criteria for an elopement risk but at no reportable, proper immediate notification and forwarding of time had "tried to leave the facility or incident reports/records to verbalized a desire to leave the facility administrative staff for timely thus has adjusted well to living at the reveiw and response including facility and it is felt that the resident is not reporting to ISDH.IV. As a means

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
			B. WING			09/13/20	011
			B. WIII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ROWNPOINTE CIRCLE		
CROWN	POINTE OF ANDER	RSON			SON, IN46012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	at risk and will remain at the facility".				to ensure ongoing compliand wth notifcation of the ISDH o		
		ed the decision to not			unusual occurrence within 24		
		vithin a secured facility			hours of an unusual occurrer		
	had been address	ed with the resident			within 24 hours of becoming		
	family/responsib	le party and all concurred			aware of the occurrence,		
	with the resident	remaining at the facility.			administrative staff shall be responsible to report to the		
	During an intervi	iew on 9/12/11 at 9:40			corporate structure on a wee basis continued review of	kly	
	_	r of Nursing indicated the			incidents occurring within the	,	
	1 '	"locked" facility. She			facility and comparison to		
	1 -	ne exterior doors were			Reporting Guidance to confir	m	
		alarm was not on during			necessity of reporting, as		
		_			applcable, and to confirm continued compliance therev	vith	
		s. She indicated the door			Continued Compliance therev	vitii.	
		ed on at 7:00 p.m. and					
		ng the night. She					
		ident could exit the					
	building during d	laytime hours and no					
	alarm would sou	nd.					
	A nursing note, d	lated 8/24/11 at 11:20					
	a.m., indicated th	ne following:					
	"At 9:45 a.m., re	sident was found out of					
	· ·	on grass. States she was					
		ay [Highway 32 visible					
		e to the facility] "to throw					
	herself in front of a car." States she has						
		room. [Name of home					
	health care agence						
	therapist] present for therapy. Resident						
	ambulated back to building with therapist.						
	Call placed to son. At 10:30 a.m., [name						
	of home health c	are agency] nurse was in					
	and was instructed	ed by her director to call					

Facility ID:

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			09/13/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIER	L			ROWNPOINTE CIRCLE		
CROWN	POINTE OF ANDER	RSON			RSON, IN46012		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWINED'S DI AN OF CORRECTION	OVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	911. [Name of h	ome health care agency]	İ				
	nurse called son	and doctor's office.					
	Name of medica	al doctor] office returned					
	l =	. to send resident for eval					
	[evaluation]"	. to some resident for ever					
	[evaluation]						
	During an interview with the						
	Administrator De	esignee and DoN on					
		a.m., they indicated the					
		e agency staff had found					
	the resident in the grass around to the side						
		ad summoned facility					
		The resident had walked					
		ay with her walker					
		e of the building. They					
		ere not sure what time the					
		the building, but had					
		ty for breakfast that					
		Administrator Designee					
		ove noted resident					
	_	expressions of suicidal					
		t been reported to the					
	ISDH.						
		irrent facility policy,					
	1	ided by the Administrator					
		2/11 at 10:40 a.m., titled					
	"Unusual Occurr	rences", included, but was					
	not limited to, th	e following:					
	"Policy:						
	1	l insure that the division					
	is immediately in	nformed by telephone or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 09/13/2011	
	PROVIDER OR SUPPLIER		2727 C	ADDRESS, CITY, STATE, ZIP CODE ROWNPOINTE CIRCLE RSON, IN46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
R0214	(a) An evaluation of the resident shat admission and shat semiannually and change in the resident licensed nurse shat needs of the resident substantial change condition for 1 of from the building ideations in sample. The clinical recorreviewed on 9/12 Diagnoses for Rewere not limited heart failure, dial	review and interview, the ensure a resident was owing a known ge in the resident's f 1 resident who eloped g and expressed suicidal ble of 4. (Resident #B)	R0214	In regards to Resident B as result of this incident the rewas re-evaluated by the He and Services Director on 9/ and was put on 30 minute monitoring checks for eloperisk. Resident B was also evalutated by a mental hea clinician who recommended the resident return to the as living environment with counseling for anger reaction Although it was believed by clinician the resident's exit the facility was due to ange lacking suicidal intent, the frontinues to consider Residual risk for elopement. The resident had not exhibited exit-seeking behavior nor votal desire to leave the facility however, the facility continues to continues to consider Residual risk for elopement.	sident ealth /14/11 ement  Ith d that esisted on. o the from er, and acility dent B  oiced (;

012129

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED	
			B. WIN			09/13/2	011	
			_		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEF	₹		2727 CI	ROWNPOINTE CIRCLE			
CROWN	POINTE OF ANDER	RSON		1	SON, IN46012			
(X4) ID	CUMMADV	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE	
1710	•			1710	every 30 minute checks to		Ditte	
	1 ^	tisk Assessment, dated			confirm the whereabouts of t	he		
	1	ed Resident #B was			Resident until deemed no lo			
	1	n elopement risk because			appropriate by the mental he			
	she was mobile	and had dementia. The			clinician. All residents have t	he		
	form indicated tl	ne resident met the			potential to be affected by th			
	criteria for an ele	opement risk but at no			deficient practice. Residents			
	1	o leave the facility or			be assessed on admission a			
		ire to leave the facility			every 3 months. Any substar change or event in residents			
		d well to living at the			health or behavior will			
	1	_			beevaluated immediately and	d		
		felt that the resident is not			appropriate measures taken.			
		emain at the facility".			means to ensure ongoing			
	The form indicate	ted the decision to not			compliance in ensuring a res			
	seek placement	within a secured facility			is re-evaluated following a kr	nown		
	had been address	sed with the resident			substantial change in the			
	family/responsib	ole party and all concurred			resident's condition and/or u return from hospitalization.	pon		
	1 -	remaining at the facility.			Administrative staff shall be			
					responisble to review staff re	ports		
	During an interv	iew on 9/12/11 at 9:40			daily on schedule days of wo			
	1 -	or of Nursing indicated the			as well as review shift-to-shi	ft		
	1	_			reporting in an effort to ident			
	1 *	a "locked" facility. She			any change in condition and			
		he exterior doors were			affirm that the same, if obser			
		alarm was not on during			was followed by a re-evaluat current care and to ensure the			
	the daytime hour	rs. She indicated the door			the service plan remains	ιαι		
	alarms were turn	ned on at 7:00 p.m. and			appropriate to the needs of t	he		
	remained on dur	ing the night. She			resident. Further, staff shall l	ре		
	indicated any res	sident could exit the			responsible to inquire of the			
	1	daytime hours and no			resident and family of any re			
	alarm would sou	-			in care following hospitalizati	on,		
	alailii would sou				as well as review any accompanying paperwork/re	norte		
	A murgina mata	datad 9/24/11 at 11:20			in an effort to ensure any	ρυιισ		
	1	dated 8/24/11 at 11:20			recommendations/care need	s are		
	a.m., indicated the	ne following:			met. Administrative staff sha			
					responsible to audit for			
		esident was found out of			appropriate resident re-evalu			
	building sitting of	on grass. States she was			following a known substantia	ıl		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL	TIPLE CON	NSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	09/13/2	
			B. WING			09/13/2	011
NAME OF I	PROVIDER OR SUPPLIE	R	I .		DDRESS, CITY, STATE, ZIP CODE		
CROWN	POINTE OF ANDE	RSON			SON, IN46012		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	_	DATE
	_	ray [Highway 32 visible			change in resident's condition and/or return from hospital	n	
		te to the facility] "to throw			treatment to ensure complan	ce	
		of a car." States she has			therewith. Should non-compl		
		n room. [Name of home			be identified immedate corre	ctive	
	health care agen				action shall be taken.		
		t for therapy. Resident					
		to building with therapist.					
		on. At 10:30 a.m., [name					
		care agency] nurse was in					
		ed by her director to call					
	_	nome health care agency]					
		and doctor's office.					
		al doctor] office returned					
		. to send resident for eval					
	[evaluation]"						
	The next nursing	g note entry, dated 8/25/11					
	1	icated the following:					
		al adams a suite					
		ed yesterday evening,					
		Up this am. Pleasant and					
	_	er residents. Telling					
	1 -	her trip to ER [emergency					
	room]."						
	This was the last	t nursing note entry at the					
	time of review o	on 9/12/11 at 9:35 a.m.					
	The clinical reco	ord lacked any					
	re-evaluation of	the resident since her					
	readmission to the	he facility related to her					
	having eloped fr	om the facility and					
	expression of a s	suicidal ideation.					
	During an interv	riew with the Director of					

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PRINTED: 09/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY COMPLETED 09/13/2011	
	PROVIDER OR SUPPLIER		2727 C	ADDRESS, CITY, STATE, ZIP CODE ROWNPOINTE CIRCLE RSON, IN46012	55.15.25
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R0349	Nursing on 9/12/indicated the resire-evaluated upon from the ER after interventions had monitor her.  This State Reside Complaint #IN00  (a) The facility must on each resident. maintained under employee of the faresponsibility. The (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on record facility failed to a clinical record waccurately docum reviewed for informergency room (Resident #B) an resident's clinical	at 11:10 a.m., she dent had not been in her return to the facility or her elopement and no il been put into place to been put into place	R0349	Resident # B was re-evaluare 9/14/11. Assessments/evaluare and monitoring logs have beendocumented in application clinical record. Resident # Edischarged to a Skilled Facion 09/02/11 prior to survey. In a effort to identify any other residents who may be affected, current clinical records of all residents will be reviewed to ensure record of	ations ble was lity on n

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RVLV11

Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
			B. WIN			09/13/2	011
NAME OF I	PROVIDER OR SUPPLIEF			1	ADDRESS, CITY, STATE, ZIP CODE		
CROWN	POINTE OF ANDER	RSON		1	ROWNPOINTE CIRCLE ISON, IN46012		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	i E	DATE
	Findings include  1. The clinical rewas reviewed on Diagnoses for Rowere not limited heart failure, diagnoses for Rowere not limited heart from the entrance heart from the entrance herself in front of things missing in health care agency therapist] present ambulated back Call placed to so of home health cand was instructed for the place of the	ecord for Resident #B 19/12/11 at 9:35 a.m. esident #B included, but to, dementia, congestive betes mellitus type 2, ase, and depression.  dated 8/24/11 at 11:20 ne following: sident was found out of on grass. States she was ay [Highway 32 visible e to the facility] "to throw if a car." States she has a room. [Name of home cy] PT [physical t for therapy. Resident to building with therapist. in. At 10:30 a.m., [name are agency] nurse was in ed by her director to call come health care agency]			CROSS-REFERENCED TO THE APPROPRIATE	ed to on ent or eff on ould	
		and doctor's office.					
	l <sup>-</sup>	al doctor] office returned					
		. to send resident for eval					
	[evaluation]"						
	1	note entry, dated 8/25/11 icated the following:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ		INSTRUCTION 00	(X3) DATE : COMPL		
THIND I LIMIT	or connection	IDENTIFICATION NONDER.	A. BUII			09/13/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	ROWNPOINTE CIRCLE		
CROWN	POINTE OF ANDER	RSON			SON, IN46012		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	REGULATORT OR	LSC IDENTIFFING INFORMATION)	+	IAG	DEFICIENCE TY		DATE
	"Dagidant raturn	ed yesterday evening,					
		Up this am. Pleasant and					
		er residents. Telling					
	_	ner trip to ER [emergency					
	room]."	er up to Exclonergency					
		nursing note entry at					
		n 9/12/11 at 9:35 a.m.					
		rd lacked any return					
		the emergency room					
	-	ossible new orders and/or					
	follow-up care no	eeded.					
	During an intervi	iew with the Director of					
		on 9/12/11 at 10:55 a.m.,					
	• • •	nation was requested					
		k of emergency room					
		ation noted above. She					
	_	ility did not receive a					
	copy of the emer	gency room discharge					
	information for F	Resident #B. She stated					
	this information	is given to the families					
	when they take re	esidents to the ER and the					
	facility does not	get this information					
	-	tells them of a new					
	medication order	and/or follow-up care					
	needed.						
	During an intervi	iew on 9/12/11 at 1:20					
	_	dicated she had obtained					
	*	ergency room discharge					
		cated two new medication					
	orders had been v	written for the resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE S COMPL	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDIN	NG	00	09/13/20	
			B. WING	TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ROWNPOINTE CIRCLE		
	POINTE OF ANDER				SON, IN46012		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG		visit. The new orders	1	AU	,		DAIL
		dal (an antipsychotic					
	1	milligrams once tablet					
	l '	bs ordered) and Ativan					
	(an antianxiety m	-					
	l ` •	times daily as needed for					
	~	ordered). The discharge					
	l * `	indicated the resident					
	was to have a fol	low-up appointment with					
		sician in 7 days. The					
	DoN indicated sh	ne was not aware of these					
	orders prior to 9/	12/11.					
	2. Resident #E's	clinical record was					
	reviewed on 9/13	3/11 at 9:20 a.m.					
	The resident's dia	agnoses included, but					
	were not limited	to, hypertension, angina,					
	degenerative join	nt disease, and					
	osteoporosis.						
		a 4/24/11, Service Plan.					
		indicated the resident					
	· ·	ated, and had some					
		ecisions in new situations.					
		indicated the resident					
	1	with toileting and					
	ambulation.						
	Davious of a 0/10	1/11 2:00 n m . Dracraca					
	Review of a 8/10	/11, 2:00 p.m., Progress					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMPI 09/13/2	LETED	
	PROVIDER OR SUPPLIER		2727 C	ADDRESS, CITY, STATE, ZIP CODE ROWNPOINTE CIRCLE RSON, IN46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	[DoN] indicated	the Director of Nursing the resident had several ne past few weeks on ad 8/10/11.				
		rd lacked any elated to the resident on 8/2/11 and 8/3/11.				
	9/13/11 at 9:00 a the only nurse or permitted to docu record. She indic communication f	iew with the DoN on .m., she indicated she is a staff and the only one .ument in the clinical cated CNA's leave a for her about resident falls atts them when she returns				
	This State Reside Complaint #IN00	ential tag relates to 0095111.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE  A. BUILDING  B. WING	E CONSTRUCTION  00	(X3) DATE COMPI 09/13/2	LETED	
NAME OF PROVIDER OR SUPPLIER  CROWNPOINTE OF ANDERSON			272	EET ADDRESS, CITY, STATE, ZIP OF THE CIRCL DERSON, IN46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
R0354	(1) Identification d (2) Name of the tra (3) Name of the resort transfer. (4) Resident 's pertransferred to an a second form of transfer informat a second facility failed to transfer informat a resident review hospital following expression of suits ample of 4. (Reference of the second facility failed to transfer informat a resident review hospital following expression of suits ample of 4. (Reference of the second facility failed to transfer informat a resident review hospital following expression of suits ample of 4. (Reference of the second facility failed to transfer informat a resident review hospital following expression of suits ample of 4. (Reference of the second facility failed for the clinical record facility failed for the clinical record facility failed for the second facility failed fa	ansferring institution. Eceiving institution and date ersonal property when acute care facility. Erelating to the resident 's: ties and physical limitations;  If d condition on transfer.  Array and skin test for review and interview, the ensure all required ion was provided for 1 of red who was sent to the ag an elopement and cidal ideations in a esident #B)  Erd for Resident #B was 2/11 at 9:35 a.m.  Resident #B included, but to, dementia, congestive etes mellitus type 2, ase, and depression.  Idated 8/24/11 at 11:20	R0354	In regards to resider result of this inciden form has been deverequired transfer infimplemented for restransfers to the hosp residents have the paffected by the deficat ransfer form has developed with the information and impall resident transfers hospital. As a means compliance all staff inserviced on the ustransfer form and whinformation is required the transfer form. As ensure ongoing comensuring all required information is provided adminstrative staffs correct completion of form on scheduled to ensure all pertients included to ensure	at a transfer eloped with cormation and sident pital.All cotential to be cient practice, been required elemented for s to the s of ongoing will be se of the hat pertient red to be on s a means to enpliance in d transfer ded. chall reveiw for of the transfer days of work t information	09/30/2011

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Event ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION  00	r í	E SURVEY PLETED	
NAME OF I	DROVIDED OD CLIDDLIED		B. WING STREET	Γ ADDRESS, CITY, STATE, ZIP COD		2011
	PROVIDER OR SUPPLIER POINTE OF ANDER		I	CROWNPOINTE CIRCLE ERSON, IN46012		
				1		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOW		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE
1AG	"At 9:45 a.m., rebuilding sitting of headed to highward from the entrancherself in front of things missing in health care agend therapist] present ambulated back to Call placed to so of home health cand was instructed 911. [Name of home health cand was instructed 911. [Name of home health cand was instructed 911. [Name of medical at 11:20 a.m. [evaluation]"  The clinical recomposition of the composition of the composition of the composition of the composition of the called the called the ER was sent out, but could called the ER register of the composition of the called the ER register of the could be called the ER register of the called the E	sident was found out of on grass. States she was ay [Highway 32 visible e to the facility] "to throw f a car." States she has a room. [Name of home ey] PT [physical t for therapy. Resident to building with therapist. In. At 10:30 a.m., [name are agency] nurse was in ed by her director to call some health care agency] and doctor's office. In doctor office returned at the send resident for eval or and the send resident to the	TAG	assessment and treatm resident's need(s). Shot transfer occur while ad staff is off-site, upon renext tour of duty, admir staff shall audit for corrommunication of transinformation. Should non-compliance be ide immeditate corrective abe taken.	ould minstrative turn or nstrative ect sfer nitified,	DATE

l '			(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	COMPL 09/13/2	
			B. WING			09/13/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
CROWN	POINTE OF ANDER	RSON	<b>I</b>		ROWNPOINTE CIRCLE SON, IN46012		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	Tz	AG	DEFICIENCY)		DATE
		She indicated she could					
	_	f the ER was aware of the					
	_	sion of suicidal ideations,					
	but she knew the	ambulance staff was					
	aware.						
		of the "face sheet" and					
	1 2	s on 9/12/11 at 11:00					
	,	ng required transfer form					
		not included in the					
	information cont	ained on those two					
	records sent with	the resident to the					
	hospital:						
	Name of receiving	g institution and date of					
	transfer						
	Resident's persor	nal property when					
	transferred to an	acute care facility					
	Nurses's notes re	lating to the resident's					
	functional abilitie	es, physical limitations,					
	and nursing care						
	_	ay and skin test for					
	tuberculosis	•					
	This required inf	formation would not have					
		the two forms sent with					
		ese forms did not include					
		filled in documenting					
		was being sent to the					
	hospital.	50 50 60 6110					